PORTSMOUTH COMMUNITY HEALTH CENTER, INC.
dba HAMPTON ROADS COMMUNITY HEALTH CENTER

VERIFICATION OF INCOME FOR SLIDING FEE ELIGIBILITY

- **Form 1040** US Individual Income Tax Return for prior calendar year
- **SSA-Award letter** Social Security Benefit Statement **if not required to file an income tax return**
- **Social Services** Notice of Action for Food Stamp Allotment that shows Gross Monthly Income
- **VEC W6** will be accepted ***TEMPORARILY*** until one of the above forms is available. W6 forms must be updated every 3 months.

Your co-pay/nominal fee will be determined by your proof of income and family household as set by the Health & Human Services Poverty Guidelines and will fall into one of the following categories:

Category	***Income as Percent of Poverty Level***	***Nominal Fee MEDICAL***	***Nominal Fee DENTAL***	***Nominal Fee BEHAVIOR HEALTH***
A	**100% and below**	**$25 **Lab fee is separate****	**$67 Comprehensive exam and x-ray Emergency at $112 Preventive dental visit $55 (Must have current exam)**	**$5**
		Co-pay MEDICAL	***Co-pay DENTAL***	***Nominal Fee BEHAVIOR HEALTH***
B	**Greater than 100% up to 125%**	**$35 **Lab fee is separate****	**$89 Comprehensive exam and x-ray Emergency at $139**	**$10**
C	**Greater than 125% up to 150%**	**$45 **Lab fee is separate****	**$111 Comprehensive exam and x-ray Emergency at $166**	**$10**
D	**Greater than 150% up to 175%**	**$55 **Lab fee is separate****	**$133 Comprehensive exam and x-ray Emergency at $193**	**$10**
E	**Greater than 175% up to 200%**	**$65 **Lab fee is separate****	**$155 Comprehensive exam and x-ray Emergency at $200**	**$10**

Total Qualifying Income _____________
Family Size _____
Category_______ and medical co-pay $__________ Dental copay/deposit of $___________/____________
(copay) (deposit)

I agree the above information is true and accurate to the best of my knowledge and accept the services of Portsmouth Community Health Center, Inc. (PCHC) based on the above. If the information above has been given falsely with the intent to defraud, I realize that Portsmouth Community Health Center, Inc. has the right to take appropriate action to recover any charges that may occur as a result of giving false information. Any changes to income and/or family size are to be reported immediately. **Re-verification is due ____________________, pending no changes.**

Print Patient Name: ______________________________Signature of patient_________________________________

Printed name of Interviewer _____________________________Signature of interviewer: ______________________

Date signed ________________________________

(2019 Federal Poverty Levels)						
	Sliding Scale					
	A	B	C	D	E	F
Family Size	100% and Below	Between 100% and up to 125%	Between 125% and up to 150%	Between 150% and up to 175%	Between 175% and up to 200%	Full Pay
1	12,490	15,613	18,735	21,858	24,980	
2	16,910	21,138	25,365	29,593	33,820	
3	21,330	26,663	31,995	37,328	42,660	
4	25,750	32,188	38,625	45,063	51,500	
5	30,170	37,713	45,255	52,798	60,340	
6	34,590	43,238	51,885	60,533	69,180	
7	39,010	48,763	58,515	68,268	78,020	
8	43,430	54,288	65,145	76,003	86,860	
Note: For families/households with more than 8 persons, add $4,420 for each additional person.						